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PLUNKETT,T.F. Florida Power & Light Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 92-012-00:on 921031,station personnel discovered Unit 3 airlock to atmosphere vent valve opened.Caused by personnel error.Procedure revised,providing post maint,pre-refueling verification & associated training.W/921125 ltr.

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L-92-312
10 CFR 50.73

NOV 25 1992

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D. C. 20555

Gentlemen:

Re: Turkey Point Unit 3
Docket No. 50-250
Reportable Event: 92-012-00
Containment Personnel Airlock Vent Inadvertently Open to Atmosphere During Core Alterations

The attached Licensee Event Report 250-92-012-00 is being provided in accordance with 10 CFR 50.73 (a)(2)(i)(B).

If there are any questions please contact us.

Very truly yours,

T. F. Plunkett
Vice President
Turkey Point Nuclear

TFP/JEK/jk

Attachment

cc: Stewart D. Ebneter, Regional Administrator, Region II, USNRC
Ross C. Butcher, Senior Resident Inspector, USNRC, Turkey Point Plant

IE22

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
TURKEY POINT UNIT 3	05000250	1 OF 3

TITLE (4) Containment Personnel Airlock Vent Inadvertently Open to Atmosphere During Core Alterations

EVENT DATE (5)				LER NUMBER (6)			RPT DATE (7)				OTHER FACILITIES INV. (8)	
MON	DAY	YR		YR	SEQ #	R#	MON	DAY	YR		NAME	DOCKET # (5)
10	31	92		92	012	00	11	30	92			

OPERATING MODE (2)	6	10 CFR 50.73(a)(2)(i)(B)
POWER LEVEL (10)	0	

LICENSEE CONTACT FOR THIS LER (12)

	TELEPHONE NUMBER
James E. Knorr, Regulation and Compliance Specialist	305-246-6757

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES	(If yes, complete EXPECTED SUBMISSION DATE)	NO X				

ABSTRACT (16) On October 31, 1992, at approximately 2100 hours, station personnel discovered the Unit 3 airlock to atmosphere vent valve open. At the time, Unit 3 was in Mode 6 with core alterations in progress. The valve was indicated in the closed position by the position of the linkage attached to the valve. The valve ball actuator was found to be turned 90 degrees out of its proper position and was therefore open when indicated closed and closed when indicated open. This condition resulted in the vent for the outer door being open while the inner door was open. The condition with the inner door open and the atmosphere vent valve open is contrary to the requirements of Technical Specification 3.9.4.c.1. while core alterations are in progress. The valve and associated linkage were returned to their correct configuration at 0200 hours on November 1, 1992.

The cause of the event was personnel error. Corrective actions include procedure revisions, providing post maintenance and pre-refueling verification, and associated training.

I. DESCRIPTION OF THE EVENT

On October 31, 1992, at approximately 2100 hours, station personnel discovered the Unit 3 airlock to atmosphere vent valve open (EIIS-NH IEEE-VTV). At the time, Unit 3 was in Mode 6 with core alterations in progress. Core alterations were immediately stopped. The valve was indicated in the closed position by the position of the linkage attached to the valve. The valve ball and stem were found to be turned 90 degrees out of proper position. Therefore, the valve was open when indicated closed and closed when indicated open. This condition resulted in the vent for the outer door (EIIS-NH IEEE-DR) being open while the inner door (EIIS-NH IEEE-DR) was open. The condition with the inner airlock door open and the atmosphere vent valve open is contrary to the requirements of Technical Specification 3.9.4.c.1. while core alterations are in progress. Plant personnel disassembled the linkage and reassembled the linkage and stop plate in the correct position. Maintenance was last performed on the subject valve on October 10, 1992. Review of the records produced after that maintenance indicates that work performed was performed correctly. However the configuration of the valve found on November 1, 1992 indicates that the reassembly may have been done incorrectly. Core alterations began, for the first time after the maintenance, on October 28, 1992 at 0850 hours. The valve and associated linkage were returned to their correct configuration at 0200 hours on November 1, 1992. The correct configuration of the personnel hatch was verified using operations support procedure 3-OSP-51.6, Containment Airlock Doors Operability Test.

II. CAUSE OF THE EVENT

The cause of the as-found valve configuration was a personnel error. During the reassembly of the valve and its associated linkage after maintenance, the linkage was aligned on the valve stem 90 degrees from the correct orientation. This misorientation resulted in the valve being in the closed position when indicated open and the open position when indicated closed.

III. ANALYSIS OF THE EVENT

Technical Specification 3.9.4 Containment Building Penetrations, requires, during core alterations, that a minimum of one door in each airlock be closed and that each penetration providing direct access from the containment atmosphere to the outside atmosphere be closed. The bases for this Technical Specification state that the requirements during refueling operations on containment building penetration closure and operability ensure that a release of radioactive material within the containment will be restricted in leaking to the environment. The operability and closure restrictions are sufficient to limit radioactive material release from the containment as a result of a fuel element rupture based upon the lack of containment pressurization potential during the refueling mode.

The requirements for containment closure during core alterations are satisfied by operations surveillance procedure 3-OSP-51.12, Refueling Containment Penetration Alignment. Specifically, Attachment 1, page 88 of 133 verifies that either the inner personnel access airlock door or outer personnel access door is closed. The normal configuration of the airlock doors during refueling is both doors closed with the interlocks set. With this

configuration, only one access door in the airlock can be opened at any time.

The Technical Specifications ramifications with the personnel airlock to atmosphere vent valve mispositioned are as follows:

a. The personnel hatch doors were properly interlocked to each other and therefore one door was shut at all times as required by Technical Specification 3.9.4.b.

b. During the time that the inner door was open, the personnel airlock to atmosphere vent valve provided a path from the containment through the airlock to the environment. When this occurred Technical Specification 3.9.4.c.1 was not fulfilled. Note: During these short periods of time the opening and closing of the airlock doors was under personnel control.

The Turkey Point Final Safety Analysis Report (FSAR) scenario of a fuel handling accident is bounding for the potential fuel handling accident during this fuel reload process. Specifically, the analysis assumes a fuel handling accident which occurs 50 hours after reactor shutdown with the plant having operated at 100% thermal power. During the time that the subject valve was mispositioned the reactor power had been approximately 70% thermal power during the last month of operation and the total decay time after the reactor shutdown had been in excess of 1100 hours. Therefore, the projected doses would have been less than those projected by the FSAR scenario which had projected doses well within 10 CFR 100 limits.

IV. CORRECTIVE ACTIONS

1. Maintenance personnel involved with the reassembly of the valve and linkage were counselled in accordance with Florida Power and Light policy.

2. Maintenance personnel disassembled the valve interlock linkage. The valve linkage and stop plate were then reassembled in the correct position.

3. Turkey Point will address the generic issue of valve position versus valve position indication for ball and butterfly valves by the revision of administrative procedure AP 190.28, Post Maintenance Testing, which will ensure verification of the correct orientation of the valve position with respect to the valve operator and valve position indicator. This revision and its associated training will be complete by March 1, 1993. Specific requirements will be included for the containment personnel and escape hatches. These changes will provide assurance that testing will be completed after any maintenance is performed to ensure refueling integrity.

4. To ensure a timely understanding of the issues and corrective actions recommended in this Licensee Event Report, Mechanical Maintenance personnel (mechanics, planners and supervisors) will be trained on the issues raised by December 31, 1992.

V. ADDITIONAL INFORMATION

None